

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01716

CERTIFICATE OF DEATH

01699

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Maryland</u>	
c. LENGTH OF STAY IN 1b <u>6 years</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ralph Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. STREET ADDRESS <u>Ralph AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>Graver</u> Middle <u>Cleveland</u> Last <u>ARNOLD</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 4. 1891</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance MAN Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edgar ARNOLD</u>		14. MOTHER'S MARDEN NAME <u>Florence Burke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-02-6251</u>	
17. INFORMANT <u>Mrs Beatha Mae Arnold, Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cerebrovascular Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of week <input type="checkbox"/> Not while of week <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1960</u> to <u>February 9, 1962</u> that (I) (we) last saw the deceased alive on <u>Dec 12, 1962</u> and that death occurred at <u>7:30 P.</u> M, from the cause <u> </u> and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>HAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westminster, Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lipton-Glenn Hampstead Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Quinn L. Kline</u>			

1911

THE STATE OF TEXAS

1911

(M)

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

01700
Reg. Dist. No.

01717

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Subsistence Rd. Dist 1m.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md. (District)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>BAKER</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20 1877</u>	
9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Addie Bollinger</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Unverzagt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Tom E. Baker same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>170 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis</u> DUE TO <u>3 years</u> (c) <u>Carcinoma of right Breast</u> DUE TO <u>4 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>3 years</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 19</u> , 19 <u>34</u> , to <u>Feb. 19</u> , 19 <u>62</u> that I last saw the deceased alive on <u>Feb. 14</u> , 19 <u>62</u> , and that death occurred at <u>8 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>2-19-62</u>			
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/22/62</u>		<u>Bellevue Park Cemetery</u>		<u>Amesbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01718

01701

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Union Bridge				c. LENGTH OF STAY IN 1b Three Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R. D. # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle C. Last BARNES				4. DATE OF DEATH Month Feb. Day 8 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 10, 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 8 Days 8 Hours 19 Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body & Fender Mechanic (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S. A.	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME James Barnes				14. MOTHER'S MAIDEN NAME Kitty Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-05-6530		17. INFORMANT Address Mrs. Leighton Haifley, Same as # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Prostate 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Winfield, Maryland				(County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 1/19/62 to 2/8/62 , 19____, that (I) (we) last saw the deceased alive on 2/5/62 , 19____, and that death occurred on 2/8/62 , 19____, from the causes and on the date stated above.							
22a. SIGNATURE J. H. Caricofe				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/8/62	
22c. PHYSICIAN'S NAME (Type) J. H. CARICOFE				22d. ADDRESS 118 S. MAIN ST., Union Bridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10, 1962		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Winfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Box 241, Sykesville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 12 '62	
				25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

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RECEIVED

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01712

MARYLAND
01702

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 12yrs. 3mos. 26days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Formerly 3725 Ferndale Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel		First Amelia		Middle Barnes	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 30, 1888		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Francis M. Barnes	
14. MOTHER'S MAIDEN NAME Annie Rebecca Hardy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia S21X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Pulmonary abscess DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Psychosis with cerebral arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 15, 1949 to February 11, 1962 that (I) (we) last saw the deceased alive on February 11, 1962 and that death occurred at 2:28 PM from the causes and on the date stated above					
22a. SIGNATURE Agustin del Campo		22b. DATE 2/11/62		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield Hospital, Sykesville, Maryland		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS Springfield Hospital, Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-62		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town or county) (State) Baltimore, Maryland		23e. REC'D BY REGISTRAR FEB 13 '62		23f. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

01308

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01720 CERTIFICATE OF DEATH 01703

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1 yr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg d. STREET ADDRESS 1 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sally (Sarah) Ann Knouse BARNES		4. DATE OF DEATH Month Day Year February 4, 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-86
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Knouse, dec.		14. MOTHER'S MAIDEN NAME Jane Mann, dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, generalized. (a), stating the underlying cause last. (c) Pulmonary tuberculosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis, minimal: active. CBS with cerebral arteriosclerosis, without qualifying phrase. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) INTERVAL BETWEEN ONSET AND DEATH years years			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-27-61 to 2-4-62 , 19....., that (I) (we) last saw the deceased alive on 2-4-62 , 19....., and that death occurred at 4:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 2-4-62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/62	
23c. NAME OF CEMETERY OR CREMATORY Finksburg Mth. Cemetery		23d. LOCATION (City, town or county) (State) Finksburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR FEB 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

NOV 10

1910

(M)

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01721

01704

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN TB <u>36 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u> d. STREET ADDRESS <u>2823 Linwood Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Stella</u> <u>Bartnik</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>-</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No **16. SOCIAL SECURITY NO.** - **17. INFORMANT** Springfield Hospital Records Address -

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Septicemia
 DUE TO (b) Large infected pressure sores
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) -
 DUE TO (c) -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism.
C.B.S. with cerebral arteriosclerosis with psychotic reaction

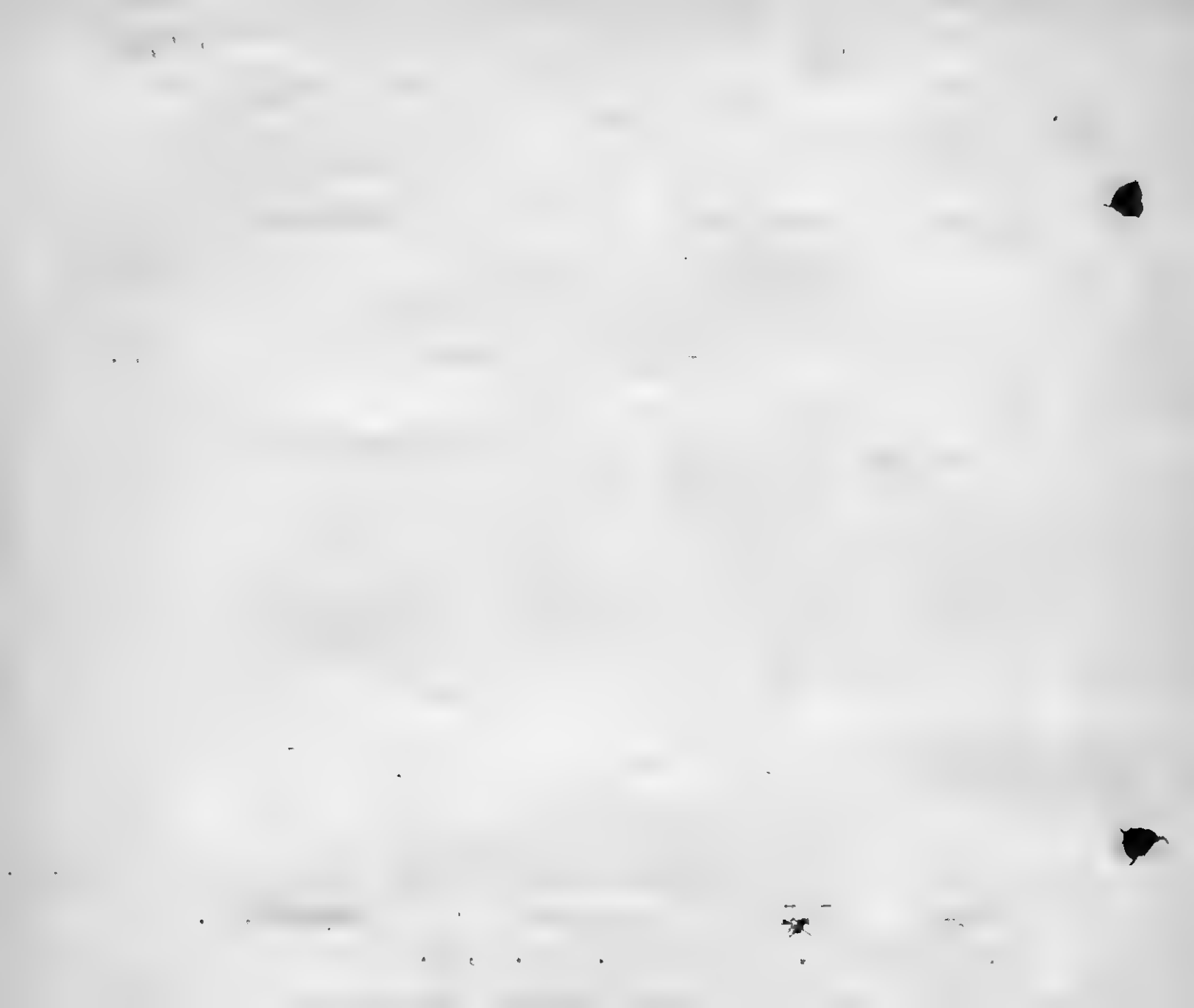
20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-6-1962 **to** 2-11-1962, **that (I) (we) last saw the deceased alive on** 2-11-1962, **and that death occurred at** 1:28 P.M. **from the causes and on the date stated above.**

22a. SIGNATURE Agustin del Campo **22b. DATE SIGNED** 2-11-1962
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. **22d. ADDRESS** Springfield State Hospital, Sykesville, Md.
ATTENDING PHYS. ☐ **MED. DIRECTOR** ☐ **STAFF PHYS.** ☒

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL **23b. DATE THEREOF** 2-15-62 **23c. NAME OF CEMETERY OR CREMATORY** Bean Cemetery **23d. LOCATION** (City, town or county) (State) SOMERSET, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. **25a. REC'D BY REGISTRAR** 16 '62 **25b. REGISTRAR'S SIGNATURE** -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01722 Items 2 & 23 film 6507 2/13/62 iwk 01705

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville. c. LENGTH OF STAY IN 1b 4ly 10m 9da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS Brought to this hospital, from Bay View Hosp. no address given for pt. at time of admission. 1927 W. Mulberry St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Karl Middle ----- Last Beaumont		4. DATE OF DEATH 2 8 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 60-?		10. IF UNDER 1 YEAR Months --- Days ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Geseck		14. MOTHER'S MAIDEN NAME Maud Sheppard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism DUE TO (b) Myocardial Failure DUE TO (c) Myocardial Fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Schizophrenia, hebephrenic type (b) purulent sinusitis, frontal			
INTERVAL BETWEEN ONSET AND DEATH Minutes Hours Months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year How - a - a - p.m. 19		20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 2-8-62 , 19 a.m. , that (I) (we) last saw the deceased alive on 2-8-62 , 19 a.m. , and that death occurred at 8:30 , from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukumsal, M.D.		22b. DATE SIGNED 2/8/62	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukumsal, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City, town or county) (State) Frederick Rd. Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George F. Schmal, etc. Fredk. Ave., Balto.		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE -----		25c. NAME & ADDRESS -----	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7(6)

1

(M)

15

1

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01723

CERTIFICATE OF DEATH

01706

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN b. <u>4 mos. 28 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 11</u> d. STREET ADDRESS <u>3350 Chestnut Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leo</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 18, 1894</u> 9. AGE (In years last birthday) <u>67</u> yrs. 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> 11. IF UNDER 24 HRS Hours <u>4</u> Min. <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Andrew Belchner</u> 14. MOTHER'S MAIDEN NAME <u>Rosa McCarthy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>218-10-3844</u> 17. INFORMANT <u>Springfield Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Far advanced bilateral pulmonary T.B., Active</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deferred.</u> 000.1		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u>19</u> p.m. 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>9-8-61</u> to <u>2-6-62</u> , that (I) (we) last saw the deceased alive on <u>2-6-62</u> , and that death occurred at <u>4:15 p.m.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Agustin del Campo</u> M.D. 22b. DATE SIGNED <u>2-6-62</u> 22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u> 22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-9-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u> 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Wright</u> ADDRESS <u>Springfield, Md.</u> 25a. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>C. S. S. S.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN b. 91 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Co. General Hospital

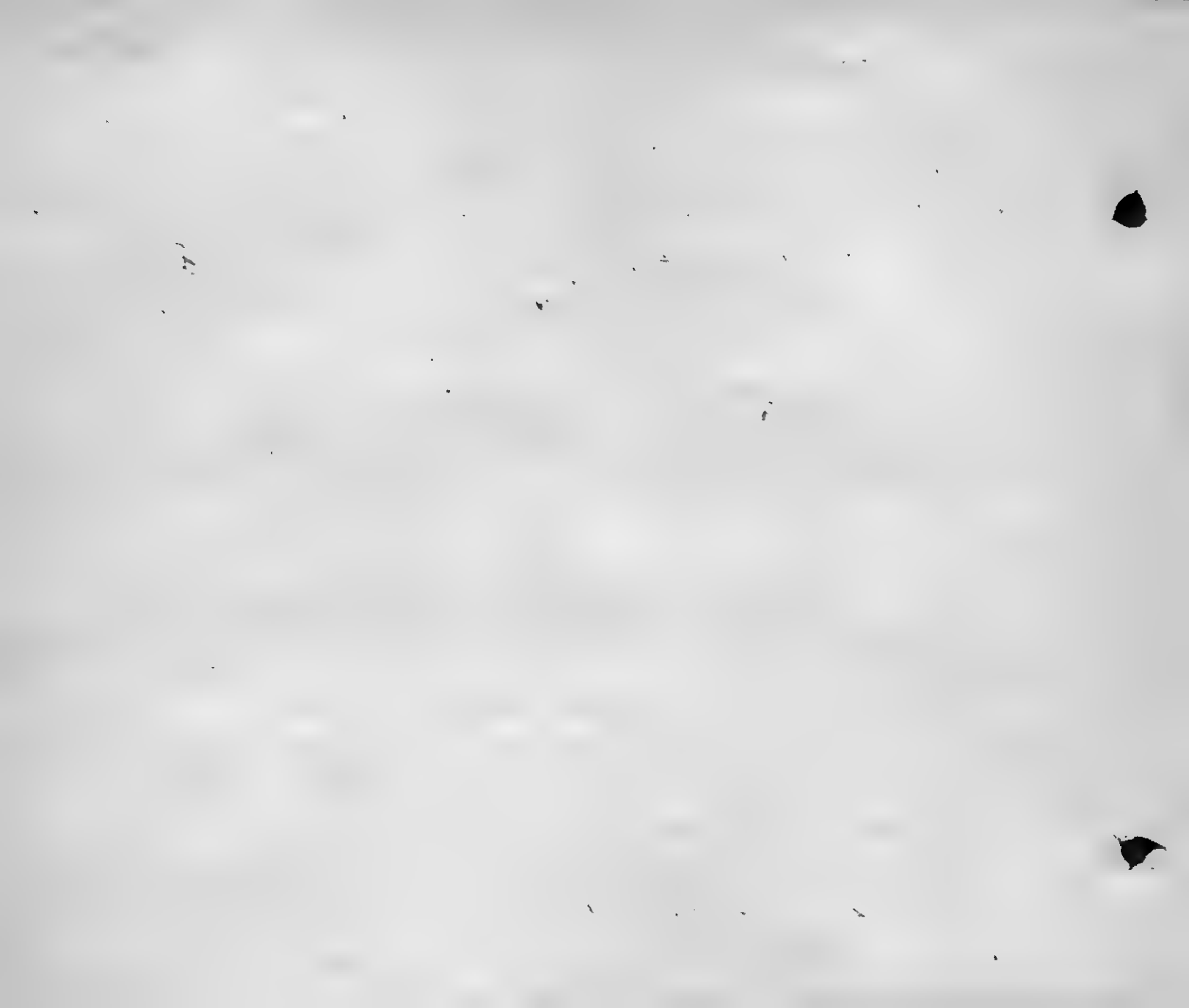
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster
d. STREET ADDRESS 25 Westmoreland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) BARBARA E. BELL
4. DATE OF DEATH Feb. 5 1962
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 10, 1970
9. AGE (In years last birthday) 91 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
11. BIRTHPLACE (State or foreign country) Westminster, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Richmond
14. MOTHER'S MAIDEN NAME Elizabeth BISTOL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Clarence R. Bell, Same address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) A.S.C.V. disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1422
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Fracture of left hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH ☒
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in bathroom
20c. TIME OF INJURY Month, Day, Year 7 p.m. 1-20 1950
20d. INJURY OCCURRED at home
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home
20f. (City or town) Westminster (County) Carroll (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE James J. Moore M.D.
EXAMINER'S NAME (Type) JAMES J. MOORE
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) 25 Westmoreland St. Westminster, Md.
DATE SIGNED 2/5/62
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/7/62
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery
22d. LOCATION (City, town, or country) Westminster, Md.
23. FUNERAL DIRECTOR J.E. Meyers, Jr., Westminster, Md.
24a. REC'D BY REGISTRAR Feb 8 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Kline

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD. d. STREET ADDRESS 505 E. MAIN ST.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD. c. LENGTH OF STAY IN b. 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HONE- 505 E. MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PATRICIA ANN BOONE		4. DATE OF DEATH Month FEB Day 8 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 23, 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) HANOVER, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PAUL C. BOONE		14. MOTHER'S MAIDEN NAME NETTIE R. STONESIFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT FATHER PAUL C. BOONE Address 505 E. MAIN ST. WESTMINSTER, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Congenital Abnormality Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 759.2 DUE TO (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) — 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Carroll 2/8/62			
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) JAMES T. MARSH		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2/9/62 22c. NAME OF CEMETERY OR CREMATORY KRIDER'S CEMETERY 22d. LOCATION (City, town, or country) (State) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR James B. Saffell Address Westminster, Md.		24a. REC'D BY REGISTRAR — 24b. REGISTRAR'S SIGNATURE — DATE FEB 9 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01726 Items 230 & d, Film G307 2/20/62 iwk 01709

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2mos. 9days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS R#4, Box 173 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Tracey Last Boyer		4. DATE OF DEATH Month February Day 14 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1885
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John H. Boyer	
14. MOTHER'S MAIDEN NAME Amanda Tracey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 } CONDITIONS IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. } DUE TO (b) Prostatic hypertrophy with urinary retention (c) C.B.S. assoc. with senile brain disease with psychotic reaction. Possible malignancy.			
19. INTERVAL BETWEEN ONSET AND DEATH Years Unknown			
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. TIME OF INJURY Month, Day, Year 12/5/61 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/5/61 to February 14, 1962 that (I) (we) last saw the deceased alive on February 13, 1962, and that death occurred at 6:20AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i> M.D.		22b. ADDRESS Springfield Hospital, Sykesville, Md.	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-62	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		25a. REC'D BY REGISTRAR FEB 15 '62	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Plante</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01727

CERTIFICATE OF DEATH

01710

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN b 6 mo. 15 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34, Maryland d. STREET ADDRESS 9039 Simms Avenue	
3. NAME OF DECEASED (Type or print) Alice Elizabeth Borgan		4. DATE OF DEATH Month 2 Day 27 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/79
9. AGE (years last b. day) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Grover		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Springfield Hospital records - Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency DUE TO 4-2-2-2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chronic brain syndrome with senile brain disease without qualifying phrase. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic brain syndrome with senile brain disease without qualifying phrase.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/12/61 to 2/27/62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/27 , 19 62 , and that death occurred at 11:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal		22b. DATE SIGNED 2/28/62	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1962	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		25a. REC'D BY REGISTRAR 5 '62	
ADDRESS 7401 Belair Road		25b. REGISTRAR'S SIGNATURE L. S. Thomas	

VR A15 4

15M 7 61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01728
01711

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 26y. 1m. 26d. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 731 Reservoir Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Richardson Last Byrn		4. DATE OF DEATH Month 2 Day 7 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/74
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 2 Days 7	11. IF UNDER 24 HRS. Hours 19 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Richardson		14. MOTHER'S MAIDEN NAME Duhamel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Springfield Hospital records - Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident Conditions, if any, which gave rise to immediate cause (b) 21X (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid reaction, paranoid state.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 12/11 , 1935 , to 2/7 , 1962 , that (we) last saw the deceased alive on 2/7 , 1962 , and that death occurred at 10:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal, M. D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 2-10-62	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		25a. REC'D BY REGISTRAR FEB 13 '62	
ADDRESS 1900 Eutaw Place		25b. REGISTRAR'S SIGNATURE John O. Mitchell	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

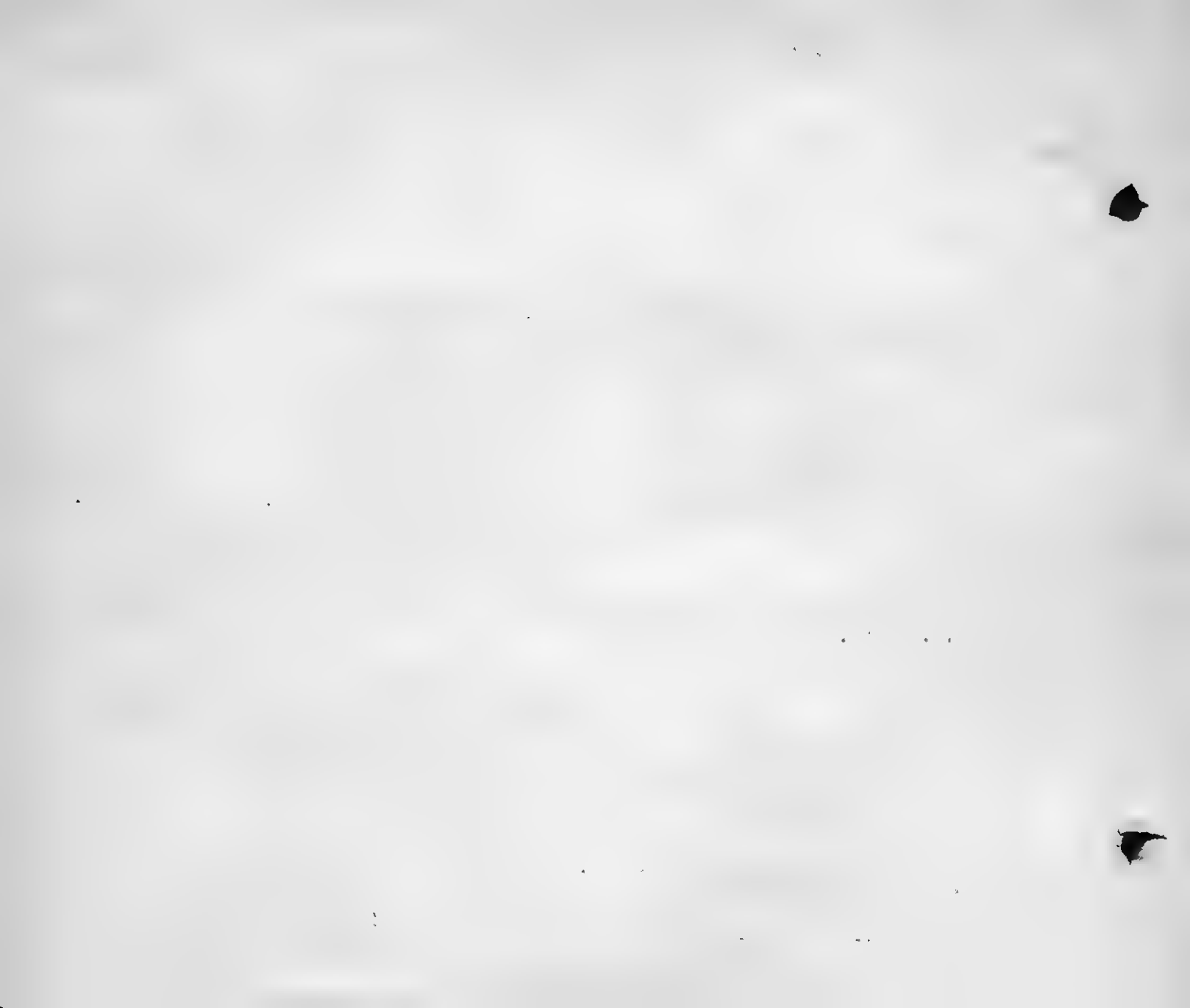
Item 9 Film G-07 2/25/62 iwk

01729

01712

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY in lb <u>8mos. 29dys.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 31</u> d. STREET ADDRESS <u>1921 E. Fayette St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Clark</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1891</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>-</u>	
14. MOTHER'S MAIDEN NAME <u>-</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>Springfield Hospital Records</u> Address <u>-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (b) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (c) <u>Due to</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Moderately advanced - Pulmonary tuberculosis.</u> <u>C.B.S. assoc. with circulatory disturbance with psychotic reaction.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u> (County) <u>1</u> (State) <u>1</u>		20g. (City or town) <u>Baltimore</u> (County) <u>1</u> (State) <u>1</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5-10-1961</u> to <u>2-9-1962</u> , that (I) (we) last saw the deceased alive on <u>2-9-1962</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Agustin del Campo</u> M.D.		22b. DATE SIGNED <u>2-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2112/62</u>		23b. DATE THEREOF <u>2112/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maternity Bldg</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>1</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. H. H. H.</u> ADDRESS <u>Reber & McD</u>		25a. REC'D BY REGISTRAR <u>Feb 15 1962</u> DATE <u>Feb 15 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01730 CERTIFICATE OF DEATH 01713

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr. 5moths 16dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 d. STREET ADDRESS 311 Ballon Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marie Connie Cullum		4. DATE OF DEATH 11 Day 2 Month 1962 Year		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1889	
9. AGE (In years last birthday) 72 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank. Deitz	
14. MOTHER'S MAIDEN NAME Mollie Elizabeth Vogel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary abscess DUE TO (c) Bed sores		INTERVAL BETWEEN ONSET AND DEATH Days Weeks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Late latent syphilis. C.B.S. assoc. with cerebral arterio. with psychotic reaction.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Old myocardial infarction, years.	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1455	
20f. (City or town) Baltimore		20g. (County) City		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 9-26-1960 to 2-11-1962 , that (I) (we) last saw the deceased alive on 2-11-1962 , and that death occurred at 1455 , from the causes and on the date stated above.					
22a. SIGNATURE Agustin del Campo 22b. DATE SIGNED 2-11-1962					
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. 22d. ADDRESS Springfield State Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-62		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. REC'D BY REGISTRAR FEB 13 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Hume	

01731

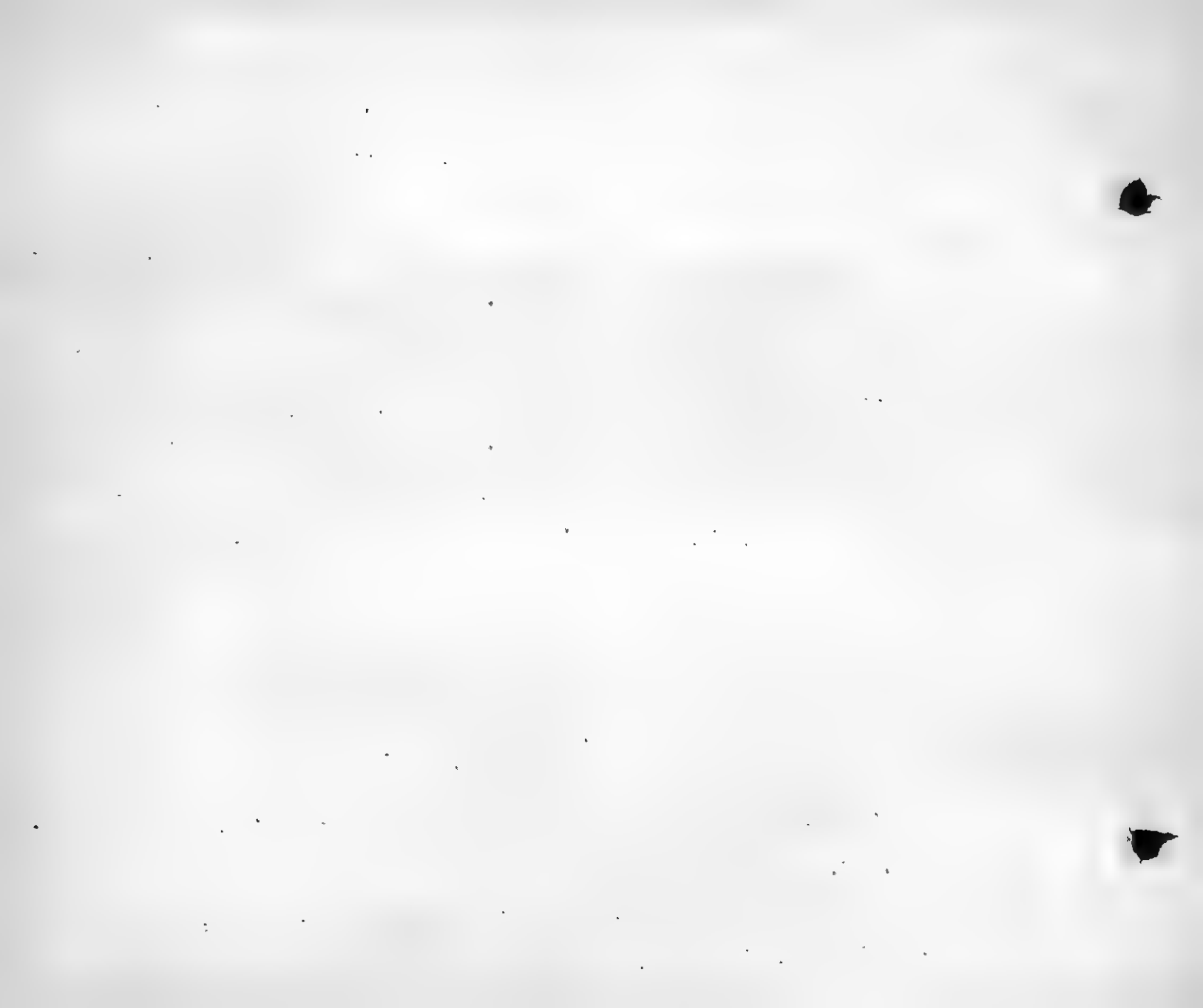
CERTIFICATE OF DEATH

Reg. Dist. **Q1714**

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-New Windsor				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural New Windsor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BETTY Middle DAVIS Last DAVIS				4. DATE OF DEATH Month February Day 3 Year 19 62			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1877	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Blackstone, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Kelley				14. MOTHER'S MAIDEN NAME Indianna Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT 2541 Madison Ave. R. W. Young, Baltimore 17, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerotic Cardio-Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/4/62 , 19____, to 2/3/62 , 19____, that I last saw the deceased alive on 1/4/62 , 19____, and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) New Windsor, Md DATE SIGNED 2/3/62							
ACTUAL SIGNATURE M. E. Robertson M.D.				PHYSICIAN'S NAME (Type) M. E. Robertson, M. D. New Windsor, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1962		22c. NAME OF CEMETERY OR CREMATORY Mt. Garazene Cemetery Blackstone, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waitz Winfield, Md.				24a. REC'D BY REGISTRAR DATE FEB 7 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01732

01715

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, c. LENGTH OF STAY IN lb 2yrs9mos10dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 d. STREET ADDRESS 612 S. Macon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Greason Eiler		4. DATE OF DEATH Month February Day 16 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1878	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 3 Days 1 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Greason	
14. MOTHER'S MAIDEN NAME Elizabeth Ziegler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Generalized arteriosclerosis. (c) Diabetes Mellitus.		INTERVAL BETWEEN ONSET AND DEATH Years Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) - (County) - (State) -	
21. I certify that (I) (this hospital) attended the deceased from... 5-6-1959 ... to... 2-16-1962 ... that (I) (we) last saw the deceased alive on... 2-16-1962 ... and that death occurred at 8:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 2-16-62	
22d. ADDRESS Springfield State Hospital, Sykesville, Md.		22e. REC'D BY REGISTRAR Charles S. Zuler	
22f. REGISTRAR'S SIGNATURE Charles S. Zuler		22g. REGISTRAR'S SIGNATURE Charles S. Zuler	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-19-62	
23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		23d. LOCATION (City, town or county) 7225 Eastern Blvd., Baltimore, Md.	
23e. REC'D BY REGISTRAR Charles S. Zuler		23f. REGISTRAR'S SIGNATURE Charles S. Zuler	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01716

01733

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankburg RD</u>		c. LENGTH OF STAY IN 1b <u>5 4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankburg</u>		d. STREET ADDRESS <u>Cedarhurst Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cedarhurst Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARSHALL</u> Middle <u>GUY</u> Last <u>FLATER</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martin-Mannett Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marshall Phillip Flater</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Blizard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>217-14-3686</u>		17. INFORMANT <u>Mrs Guy Flater, Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation - by hanging</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2-12-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frankburg RD. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr., Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>15 '62</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, omitting the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01717

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b. 1yr. 6mos. 2days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Freed		4. DATE OF DEATH Month February Day 18 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1883
9. AGE (In years last birthday) 78 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Various		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Freed		14. MOTHER'S MAIDEN NAME Thannie Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-6286	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Severe arteriosclerotic heart disease DUE TO (c) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Fracture, head of humerus. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Unknown. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Feb. 7, 1962 Hour 7 a.m. 7 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital 20f. (City or town) Sykesville (County) Carroll (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE James T. Marsh DATE SIGNED 2/19/62 EXAMINER'S NAME (Type) James T. Marsh, M.D. Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-62	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or country) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 21 '62	
24b. REGISTRAR'S SIGNATURE James T. Marsh			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

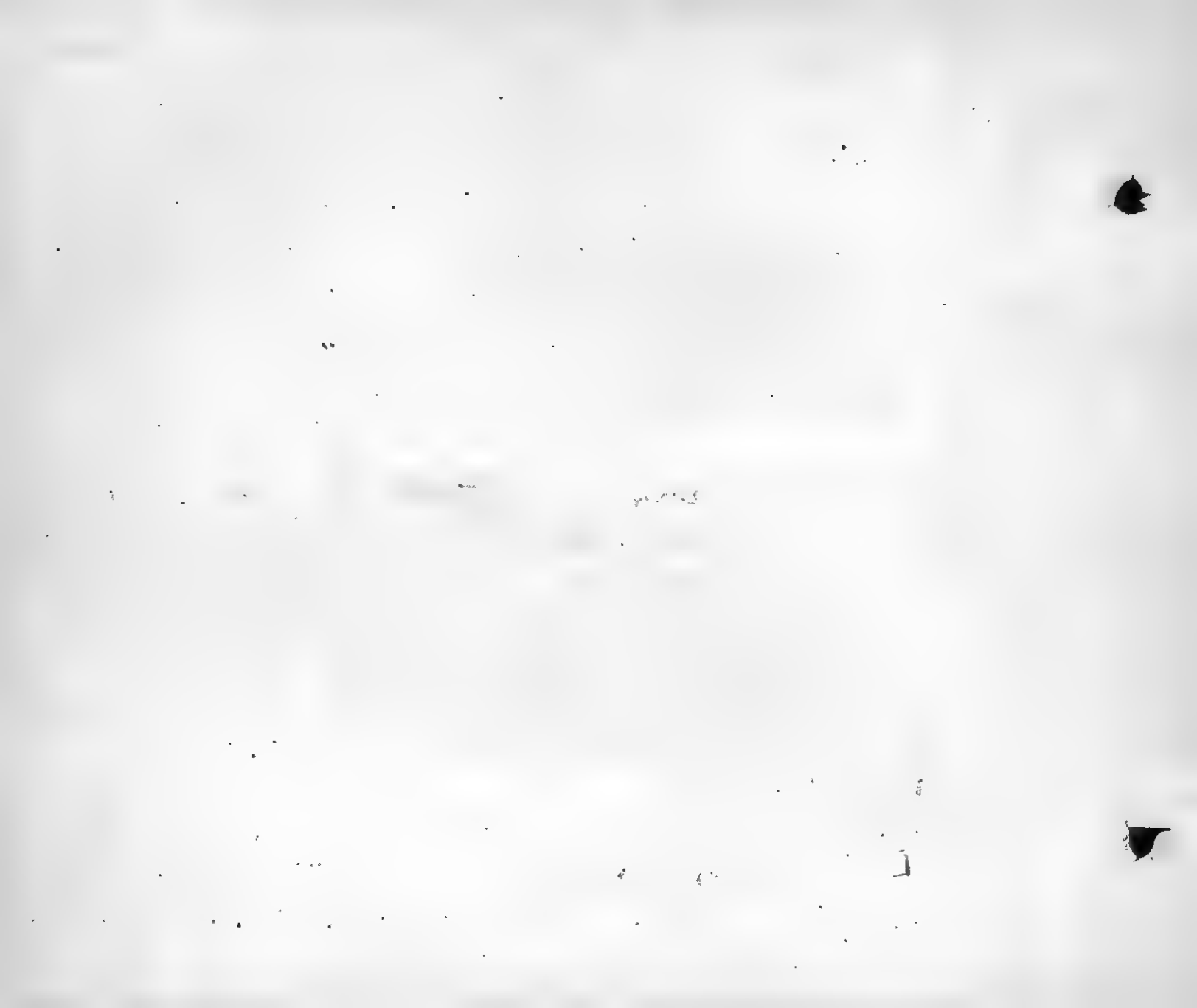
Reg. Dist. No. 01719

01736

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 27			
c. LENGTH OF STAY IN TB <u>1942</u>				d. STREET ADDRESS <u>92 Winchester Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 Winchester Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWARD FROCK</u>				4. DATE OF DEATH Month Day Year <u>Feb 18 1962</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1877</u>		9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Union Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel P. Frock</u>				14. MOTHER'S MAIDEN NAME <u>Alice Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs Wm S Frock</u>				Address <u>same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>May 1952</u> to <u>Feb 18, 1962</u> and that I last saw the deceased alive on <u>Feb 15, 1962</u> and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E Reese Wilkens</u> M.D.				ADDRESS (Street city or town, state) <u>15 Kemper Ave Westminster, Md.</u>			
DATE SIGNED <u>2/19/62</u>							
PHYSICIAN'S NAME (Type) <u>E Reese Wilkens</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		22d. LOCATION (City town, or county) <u>Rural near Windsor, Md.</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>Feb 23 '62</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01738

CERTIFICATE OF DEATH

01721

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN b. <u>1 year 7 mo 6 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore city</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1230 E. Belvedere Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Leonard Hebble</u>		4. DATE OF DEATH Month Day Year <u>Feb. 6 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-84</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> 11. IF UNDER 24 HRS. Hours <u>16</u> Mins <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hebble</u>		14. MOTHER'S MAIDEN NAME <u>Christine Wittig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>136-05-3136</u>	
17. INFORMANT <u>Springfield State Hospital Record</u>		18. ADDRESS <u>Sykesville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Inanition due to old age</u> Conditions, if any, which gave rise to immediate cause (b) <u>A.S.C.V.D.</u> (a), stating the underlying cause last. (c) <u>A.S.C.V.D.</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. Associated with cerebral Arteriosclerosis with Psychotic reaction</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-11-60</u>, 19<u>60</u>, to <u>2-6-62</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>2-6-62</u>, and that death occurred at <u>M</u>, from the causes and on the date stated above			
22a. SIGNATURE <u>Agustin del Campo</u> M.D.		22b. DATE SIGNED <u>2-6-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, Md.</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/10/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION (City, town or county) <u>BALTO., MD</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Miller - 2334 Jefferson St</u>		25a. REC'D BY REGISTRAR <u>FEB 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01722

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester MD</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>x Manchester MD</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HEINDEL, ANN LUCY</u>		4. DATE OF DEATH <u>February 7 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yak Co. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Heindel</u>		14. MOTHER'S MAIDEN NAME <u>Catherine E. Heindel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Murrell Heindel</u>		Address <u>Manchester, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 44 X DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a m p m <u>— 19 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-10 1961</u> to <u>2-7 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 23 1962</u> and that death occurred at <u>FA-M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M D		22b. DATE SIGNED <u>2-7-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>		22d. ADDRESS <u>WAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 10 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Protestant Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Yak Co MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>Star Rock, Co</u>		25a. REC'D BY REGISTRAR <u>—</u> DATE <u>Feb 13 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		25c. REGISTRAR'S SIGNATURE <u>—</u>	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01740
01723
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN IT 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson 4 d. STREET ADDRESS 8208 Loch Raven Blvd.	
3. NAME OF DECEASED (Type or print) Margaret Kauper Helgert		4. DATE OF DEATH February 5, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16, 1889
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kauper		14. MOTHER'S MAIDEN NAME Margaret Norndorfer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Diabetes Mellitus (c) Due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): C.B.S. assoc. with senile brain disease, with psychotic reaction. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
19. INTERVAL BETWEEN ONSET AND DEATH Years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-20-1962 to 2-5-1962 , that (I) (we) last saw the deceased alive on 2-5-1962 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D. 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 2-5-62 22d. ADDRESS Springfield state Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 9 1962	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEM.		23d. LOCATION (City, town or county) NORTH AVE & GAY ST MD (State)	
24. FUNERAL DIRECTOR'S SIGNATURE DIPPEL BROS ADDRESS 7110 BELAIR ROAD.		25a. REC'D BY REGISTRAR DATE FEB 7 '62	
25b. REGISTRAR'S SIGNATURE William S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01741

01724

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Taneytown</u> c. LENGTH OF STAY IN 1b <u>XXXX Frederick Street</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXXX Frederick Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Taneytown</u> d. STREET ADDRESS <u>XXXX Frederick Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Pius</u> <u>Leo</u> <u>Hemler</u> First Middle Last				4. DATE OF DEATH <u>February 15, 1962</u> Month Day Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1981</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Hardware</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Louis J. Hemler</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Goulden</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>213-01-3804</u> 17. INFORMANT <u>Mr. James D. Hemler, Taneytown, Maryland</u> Address <u> </u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> (b) <u>Perforation of Carcinoma of Stomach</u> (c) <u>Carcinoma of Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>9 mo.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>						
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> <u>1959</u> to <u>2/15</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>5/14</u> <u>1962</u> , and that death occurred at <u>7:20 AM</u> from the causes and on the date stated above															
22a. SIGNATURE <u>E. Ambler Thompson</u> 22c. PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson</u>										22b. DATE SIGNED <u>2/16/62</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>										23b. DATE THEREOF <u>2/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		23d. LOCATION (City, town or county) <u>Taneytown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Skiles</u> <u>C.O. Fuss & Son</u>										25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>			

Taneytown, Maryland

DATE FEB 19 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01742
CERTIFICATE OF DEATH
01725

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u> d. STREET ADDRESS <u>104 Westminster St</u>	
3. NAME OF DECEASED (Type or print) <u>Horatio C</u> 4. DATE OF DEATH <u>Feb 21 1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-87</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired hardware</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md</u>		11. BIRTHPLACE (Country, State, or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>George Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Greps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Mrs. Truba Black Hunt, Manchester, Md.</u> Address <u>2 days</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive arteriosclerotic</u> (a), listing the underlying cause last, (c) <u>Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 1947</u> to <u>Feb 21 1962</u> That (1) (we) last saw the deceased alive on <u>Feb 20 1961</u> , and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Foard</u>		22b. DATE SIGNED <u>2-21-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H. Foard, M.D.</u>		22d. ADDRESS <u>Manchester, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucker Fenner Jr</u>		25a. REC'D BY REGISTRAR <u>2-23-62</u> 25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

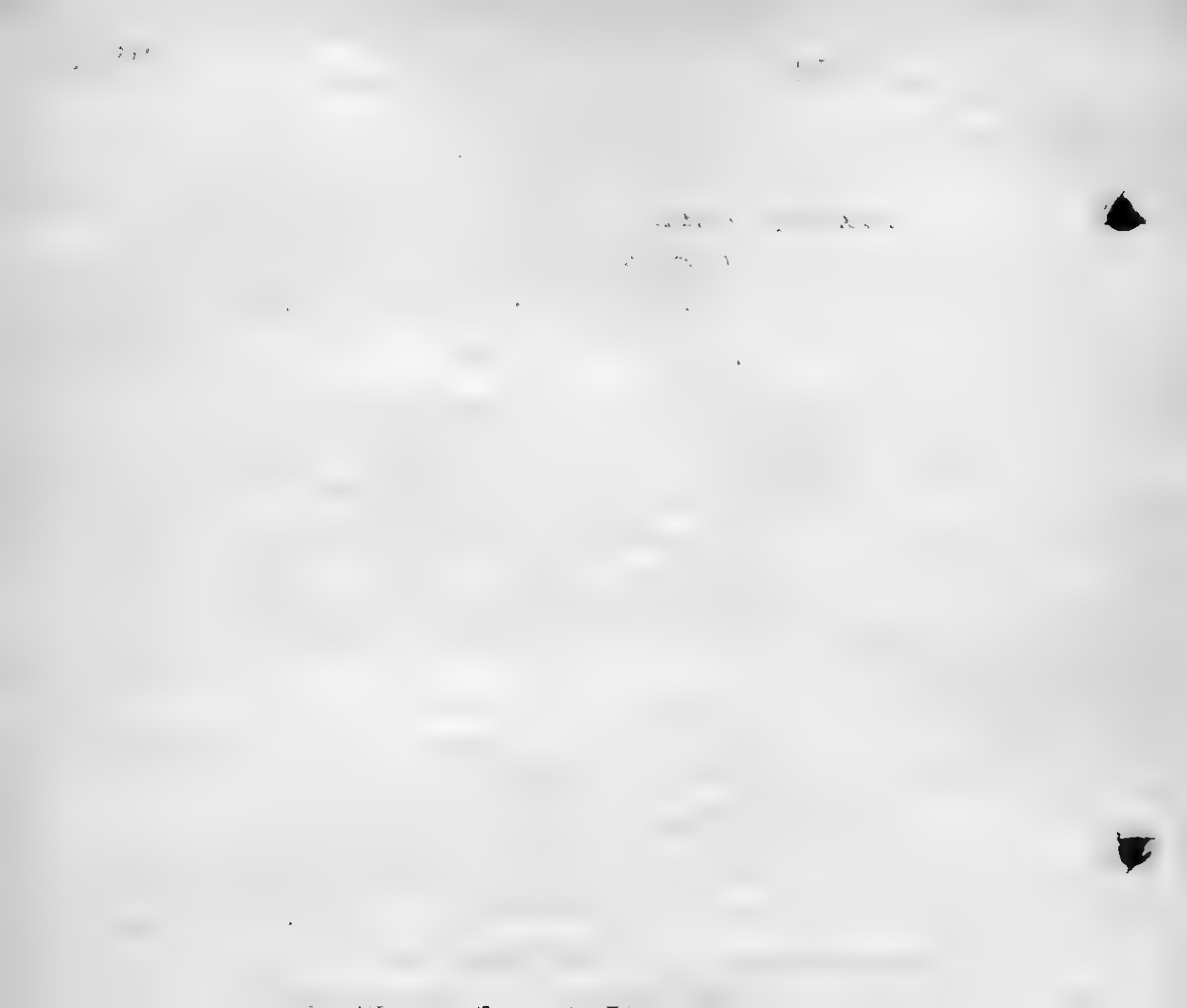
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01743

01726

1. PLACE OF DEATH a. COUNTY <u>Canell Co.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Marys</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nurs. Hm.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>_____</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> d. STREET ADDRESS <u>1507 Henry St</u>	
3. NAME OF DECEASED (Type or print) <u>JACOB HARRY IRWIN</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>10-1-1885</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M.n.		4. DATE OF DEATH <u>2-12-1962</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>G & C Co</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Wm.</u> 14. MOTHER'S MAIDEN NAME <u>Elyse Lowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Elyse Lowe</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerotic heart dis.</u> DUE TO <u>pneumonia, lesion of lower colon,</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>herpes simplex</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
INTERVAL BETWEEN ONSET AND DEATH <u>1961 to 1962</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work el work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>Feb</u> to <u>Feb</u> , 19 <u>1962</u> , that (I) (we) last saw the deceased alive on <u>12 Feb</u> , 19 <u>1962</u> , and that death occurred <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Feb 13 1962</u>			
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>B</u> 23b. DATE THEREOF <u>2-16-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem</u> 23d. LOCATION (City, town or county) (State) <u>Balto Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Hm</u> ADDRESS <u>130 E Pratt St</u> 25a. REC'D BY REGISTRAR <u>Feb 16 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01745

CERTIFICATE OF DEATH

01728

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSP</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>37 WESTMINSTER</u> d. STREET ADDRESS <u>26 GIST RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DEVEN KAY LAW</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>FEB. 16, 1962</u> 9. AGE (In years last birthday) yrs. <u>2</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>		4. DATE OF DEATH <u>FEBRUARY 18</u> 1962 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Westminster, Md</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alton D. Law</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. ca) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Alton D. Law</u> Address <u>26 Gist Road Westminster, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hornor</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) a. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURE (24 WKS GESTATION)</u> b. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>WGT 11lbs 5oz AT BIRTH</u> c. <u>INTERVAL BETWEEN ONSET AND DEATH 2 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/16, 1962</u> to <u>2/18, 1962</u> that (I) (we) last saw the deceased alive on <u>2/17, 1962</u> and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William I. Stewart,</u> M.D. 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>19 RIDGE RD, WESTMINSTER, MD.</u> 22b. DATE SIGNED <u>2/18/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/19/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery, Allentown, N.J., County</u> 23d. LOCATION (City, town or county) (State) <u>Monmouth</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Myer, Jr., Westminster, Md.</u> ADDRESS <u>Westminster, Md.</u> 25a. REC'D BY REGISTRAR <u>Anthony S. Kline</u> DATE <u>FEB 23 '62</u> 25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2) and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01746

CERTIFICATE OF DEATH

01729

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washburn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washburn</u>	
c. LENGTH OF STAY IN <u>Life</u>		d. STREET ADDRESS <u>Rd Hook Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County Civil Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie B. LOCKARD</u>		4. DATE OF DEATH <u>Feb 3 1962</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-80</u>	
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Oliver Beamer</u>		14. MOTHER'S MAIDEN NAME <u>Hester A. R. Hook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Harriet J. Lockard</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Some</u>	
26c. X DUE TO		26d. X DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		26e. X DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Feb 3</u> , 1962, that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 1962, and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James J. Marsh</u>		22b. DATE SIGNED <u>2-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>		22d. ADDRESS <u>Washburn Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Smallwood Carroll Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		24b. ADDRESS <u>Washburn Md</u>	
25a. RECD BY REGISTRAR <u>W. S. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Thomas</u>	
DATE <u>Feb 6 '62</u>			

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01747

CERTIFICATE OF DEATH

01730

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 18yrs.6mos.7da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Hagerstown, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eva Middle B. Last LOWRY		4. DATE OF DEATH Month February Day 27 Year 19 62	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-84
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian J. Willinger		14. MOTHER'S MAIDEN NAME Rachel J. Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure - old age - inanition DUE TO (b) Cardiovascular heart disease DUE TO (c) Psychosis with cerebral arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-20 1943 , to 2-27 1962 . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-27 1962 , and that death occurred at 9A M, from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal, M. D.		22b. DATE SIGNED 2-27-62	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital - Sykesville, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles Rouzer		25a. REC'D BY REGISTRAR HAR 9 '62	
ADDRESS Hagerstown Md		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01748

CERTIFICATE OF DEATH

01731

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) unknown	
c. LENGTH OF STAY IN 1b week		d. STREET ADDRESS 15X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Chorman Last Mack		4. DATE OF DEATH Month 2 Day 24 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1885
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records, Springfield State Hospital		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with heart failure DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome caused by cerebral arterio INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) sclerosis	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 2/17 1962 to 2/24 1962 , that (I) (we) last saw the deceased alive on 2/24 1962 , and that death occurred at 3:35 pm from the causes and on the date stated above.			
22a. SIGNATURE Adnan M. Sornex, M.D.		22b. DATE 2/24/62	
22c. PHYSICIAN'S NAME (Type) Adnan M. Sornex, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 3 1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Leban		23d. LOCATION (City, town, or county) (State) Etchison, Montgomery Co. Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR MAP 6 62	
25b. REGISTRAR'S SIGNATURE C. J. D. Thomas		25c. DATE 6 62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01749

CERTIFICATE OF DEATH

01732

1. PLACE OF DEATH
a. COUNTY Carroll **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN b. 16 yrs./8 mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore #18
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3805 Elkader Rd.
d. STREET ADDRESS 3805 Elkader Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Norma Middle MC CAFFERY Last MC CAFFERY
4. DATE OF DEATH Month February Day 24 Year 1962

5. SEX female **6. COLOR OR RACE** white **7. MARRIED** ☐ NEVER MARRIED ☒ **8. DATE OF BIRTH** 2/9/73
9. AGE (In years last birthday) 89 yrs. **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) none
11. BIRTHPLACE (County & State, or foreign country) Maryland **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13. FATHER'S NAME Jessie McCaffery **14. MOTHER'S MAIDEN NAME** Mary Ellen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no **16. SOCIAL SECURITY NO.** no **17. INFORMANT** Springfield State Hospital, Sykesville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
422.1 DUE TO A.S.C.V.D. with compensated heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.R.S. assoc. with senility.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour 19 a.m. 19 p.m. **20d. INJURY OCCURRED** While ☐ at work ☐ Not While ☐ at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** Sykesville, Maryland **(County)** **(State)**

21. I certify that (I) (this hospital) attended the deceased from 6/28/55 **to** 2/24/62 **19** 19 **that (I) (we) last saw the deceased alive on** 2/24/62 **19** 19 **and that death occurred at** 6:25 a.m. **from the causes and on the date stated above.**

22a. SIGNATURE Adnan Sonmez, M.D. **22b. DATE SIGNED** 2/24/62
22c. PHYSICIAN'S NAME (Type) Adnan Sonmez, M.D. **22d. ADDRESS** Sykesville, Maryland

23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL **23b. DATE THEREOF** 2/27/62 **23c. NAME OF CEMETERY OR CREMATORY** GREENMOUNT Cem. **23d. LOCATION (City, town or county)** BALTIMORE Md. **(State)**

24. FUNERAL DIRECTOR'S SIGNATURE W. J. Ruck Inc **25a. REC'D BY REGISTRAR** DATE FEB 27 '62 **25b. REGISTRAR'S SIGNATURE** W. J. Ruck Inc



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01750 CERTIFICATE OF DEATH 01733

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 1y. 8m. 8d. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 211 d. STREET ADDRESS 808 St. Paul Street	
3. NAME OF DECEASED (Type or print) Lora First - Middle McMahon Last		4. DATE OF DEATH 2 Month 21 Day 19 Year 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/75	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 21	
11. IF UNDER 24 HRS. Days 8		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Weeks		14. MOTHER'S MAIDEN NAME Cramblitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Springfield Hospital records - Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (b) 4-20-62 (c) DUE TO (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction. INTERVAL BETWEEN ONSET AND DEATH Days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/13/1960 to 2/21/1962 , that 70 (we) last saw the deceased alive on 2/21/1961 , and that death occurred at 7:05 AM , from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyakunsal, M.D.		22b. DATE SIGNED 2/21/62	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyakunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BIRTH, CREMATION, REMOVAL (Specify) 2/22/62		23b. DATE THEREOF 2/22/62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Md		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Manly H. Newell		25a. REC'D BY REGISTRAR 1 '62	
ADDRESS Paken 8 m c		25b. REGISTRAR'S SIGNATURE Manly H. Newell	

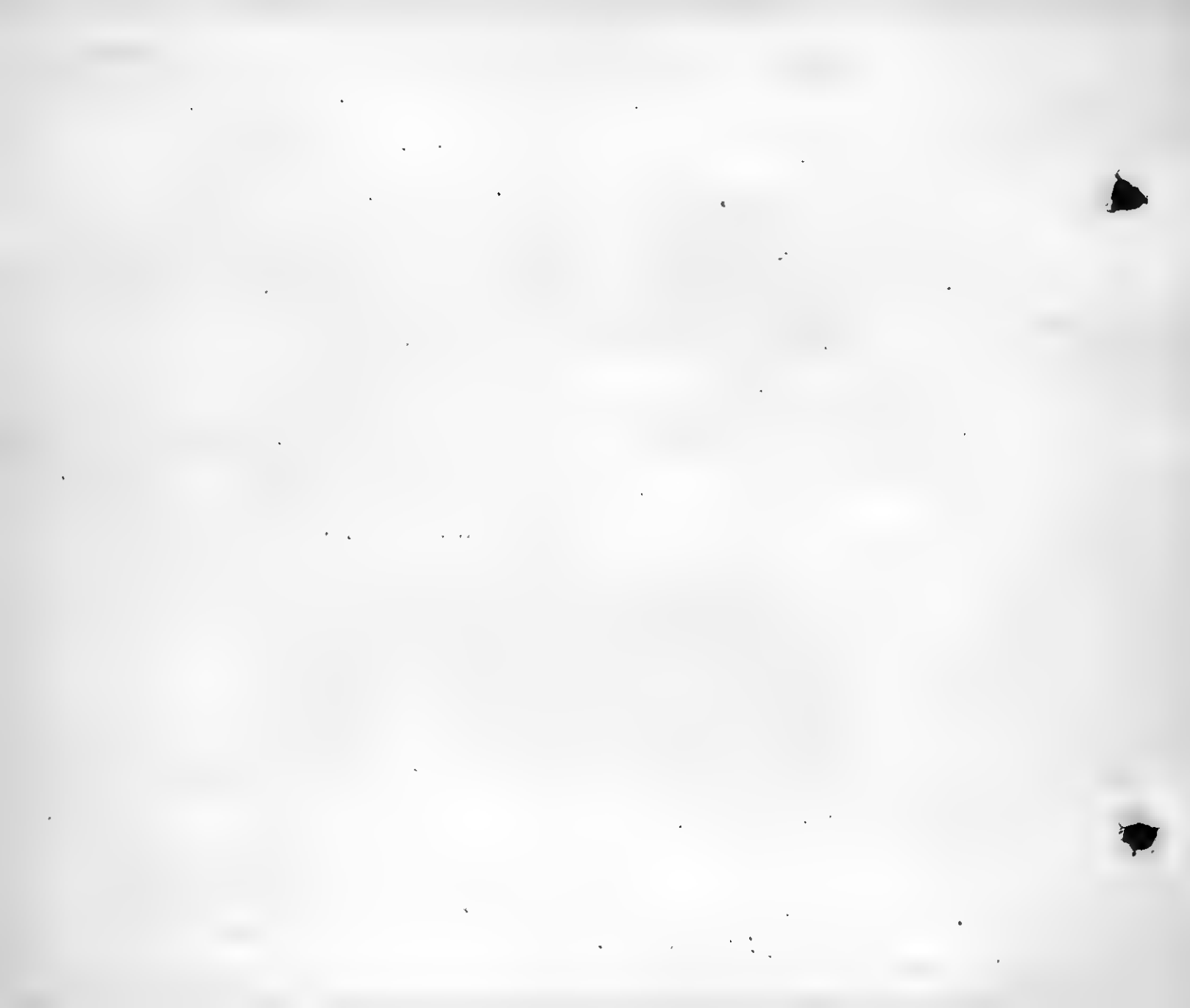
CERTIFICATE OF DEATH

Reg. Dist. **01734**

01751

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. LENGTH OF STAY IN 1b 19 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 1/2 LIBERTY STREET				e. STREET ADDRESS 155 1/2 LIBERTY STREET			
3. NAME OF DECEASED (Type or print) BESSIE STEM MICHAEL				4. DATE OF DEATH Month FEB Day 1 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 13, 1903	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE C. STEM				14. MOTHER'S MAIDEN NAME IDA MAE POOLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) NO				16. SOCIAL SECURITY NO 213-18-7435			
17. INFORMANT MR. BERNARD MICHAEL				Address 55 1/2 LIBERTY ST. WESTMINSTER.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS							
DUE TO (b) CORONARY ARTERIOSCLEROSIS							
DUE TO (c) 4 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 MIN							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from JANUARY 1958 , to FEBRUARY 1, 1962 that I last saw the deceased alive on JANUARY 12, 1962 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 19 RIDGE RD.				DATE SIGNED 2/1/62			
ACTUAL SIGNATURE William I. Stewart, M.D.				PHYSICIAN'S NAME (Type) WESTMINSTER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/3/1962		22c. NAME OF CEMETERY OR CREMATORY UNIONTOWN CEMETERY		22d. LOCATION (City, town, or county) (State) UNIONTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James A. Saffell				ADDRESS WESTMINSTER, MD.		24a. REC'D BY REGISTRAR DATE FEB 2 '62	
24b. REGISTRAR'S SIGNATURE William S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



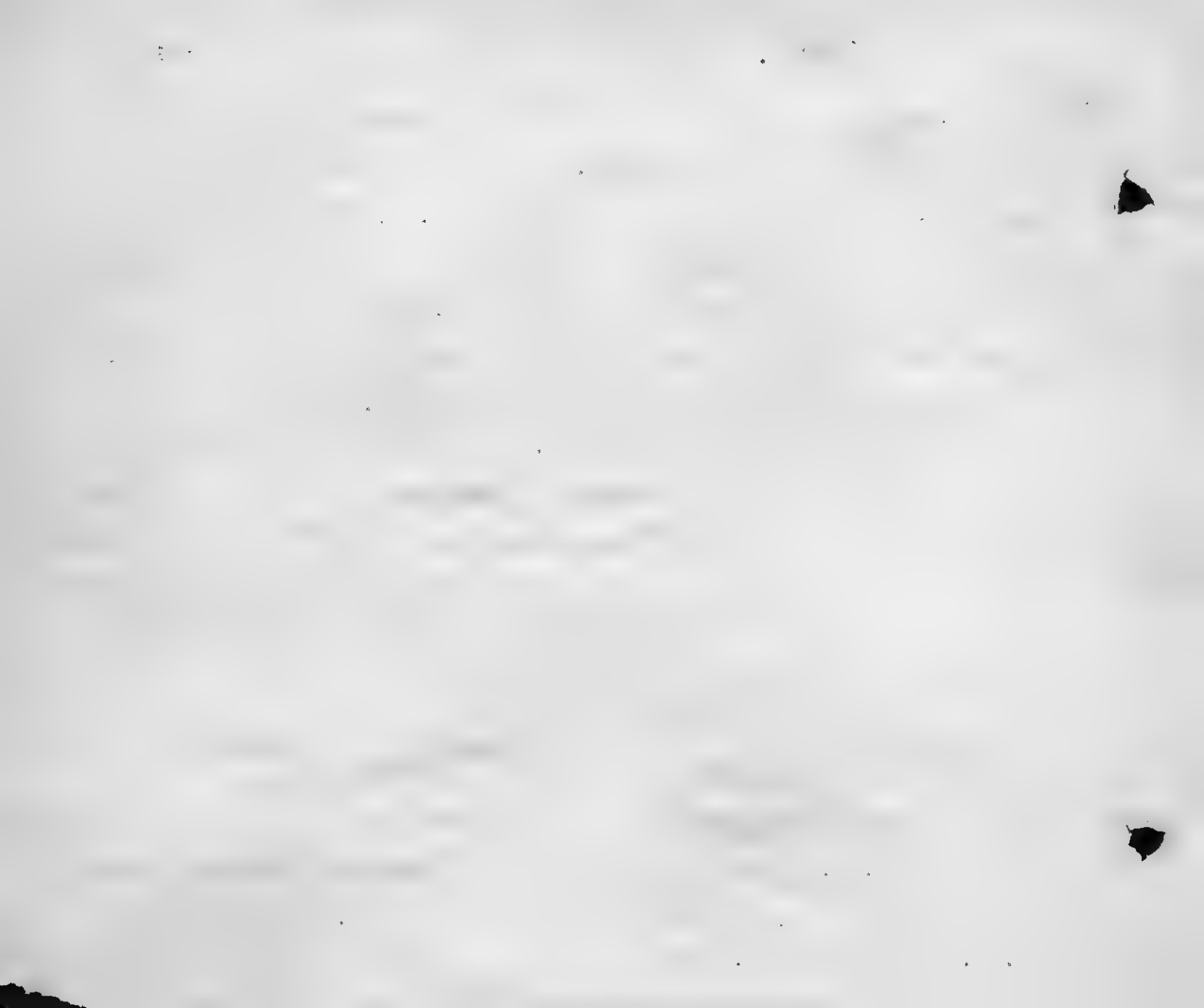
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01752 CERTIFICATE OF DEATH 01735

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Near Winfield</u> c. LENGTH OF STAY IN 1b <u>2 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R. D. 5, Westminster</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Near Winfield</u> d. STREET ADDRESS <u>R. D. 5, Westminster</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>C. ERNEST MULLINIX</u>		4. DATE OF DEATH <u>February 22, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John T. Mullinix</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Dillon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mr. E. Ray Mullinix,</u>		Address <u>Same as No. 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>arteriosclerotic C.V.D.</u> DUE TO (b) <u>2 Weeks</u> DUE TO (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/16/62</u> 19 <u>62</u> to <u>2/22/62</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/22/62</u> 19 <u>62</u> , and that death occurred at <u>11:50p</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Robertson</u>		22b. DATE SIGNED <u>2/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Robertson, M. D.</u>		22d. ADDRESS <u>New Windsor, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 25, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Mt. Airy, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Box 241, Sykesville, Md.</u>		25. REC'D BY REGISTRAR <u>Anthony S. Knaus</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>FEB 26 '62</u>	

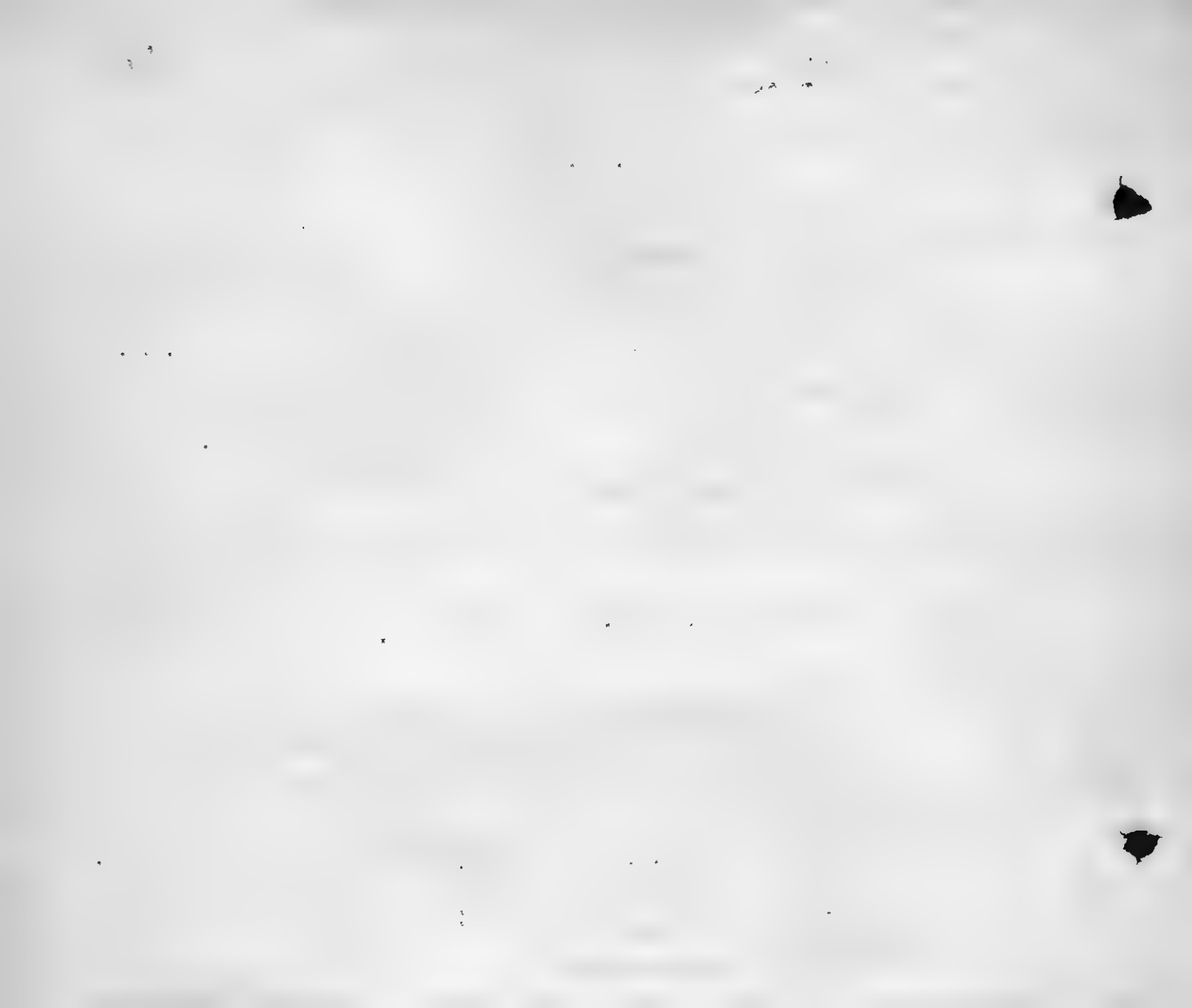


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b. 30yrs. 1mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Edward Last Munshower		4. DATE OF DEATH Month February Day 4 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1890	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Munshower		14. MOTHER'S MAIDEN NAME Emma Yinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (b) - (c) - DUE TO - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Manic depressive reaction, other. Cancer of rectum.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 - 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cancer of rectum.	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital, Sykesville, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 4, 1962 to February 4, 1962 that (I) (we) last saw the deceased alive on February 4, 1962 and that death occurred at 8:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 2/5/62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-7-62	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. K. Johnson ADDRESS Frederick, Md.		25a. REC'D BY REGISTRAR FEB 7 '62 DATE FEB 7 '62	
25b. REGISTRAR'S SIGNATURE Carroll S. Hays			



1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01737

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Keysville</u> d. STREET ADDRESS <u>1</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Keysville</u>				c. LENGTH OF STAY IN TB <u>50 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Ephriam</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David P. Myers</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stambaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-12-0159</u>			
17. INFORMANT <u>Mrs. Iva Parker, Pox 404 Sherwood Rd. Owings Mill</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u></u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>CARROLL 2/4/62</u> Address (Street, city, town, or county) <u></u>							
ACTUAL SIGNATURE <u>James T. Marsh</u>		NAME (Type or print) <u>JAMES T. MARSH</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		22d. LOCATION (City, town, or country) <u>Keysville, Carroll, Maryland</u>		22e. REC'D BY REGISTRAR <u></u>		22f. REGISTRAR'S SIGNATURE <u></u>	
23. FUNERAL DIRECTOR <u>John H. Skiles</u> <u>C. J. Fuss & Son, Taneytown, Maryland</u>				24a. DATE <u>FEB 6 '62</u>			



01755 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01738

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, the certificate may be executed within 72 hours after death. The certificate shall be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN IS <u>7yrs. 9mos. 9days</u>		d. STREET ADDRESS <u>408 Park Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie Carey Gover</u>		4. DATE OF DEATH <u>February 13, 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 18, 1869</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Gover</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>C.B.S. assoc. with dist. of metabolism, with senile brain disease with psychotic reaction. Fracture, both inferior rami. Bilateral pneumonia.</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>1/18/62</u> Hour a.m. <u>-</u> p.m. <u>-</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u> 20f. (City or town) <u>Sykesville</u> (County) <u>Carroll</u> (State) <u>Maryland</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>2/13/62</u>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u> </u>		22b. LOCATION (City, town, or country) (State) <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lovettsville Union Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Lovettsville, Va.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler</u> <u>1331 F. Adams Avenue</u> <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

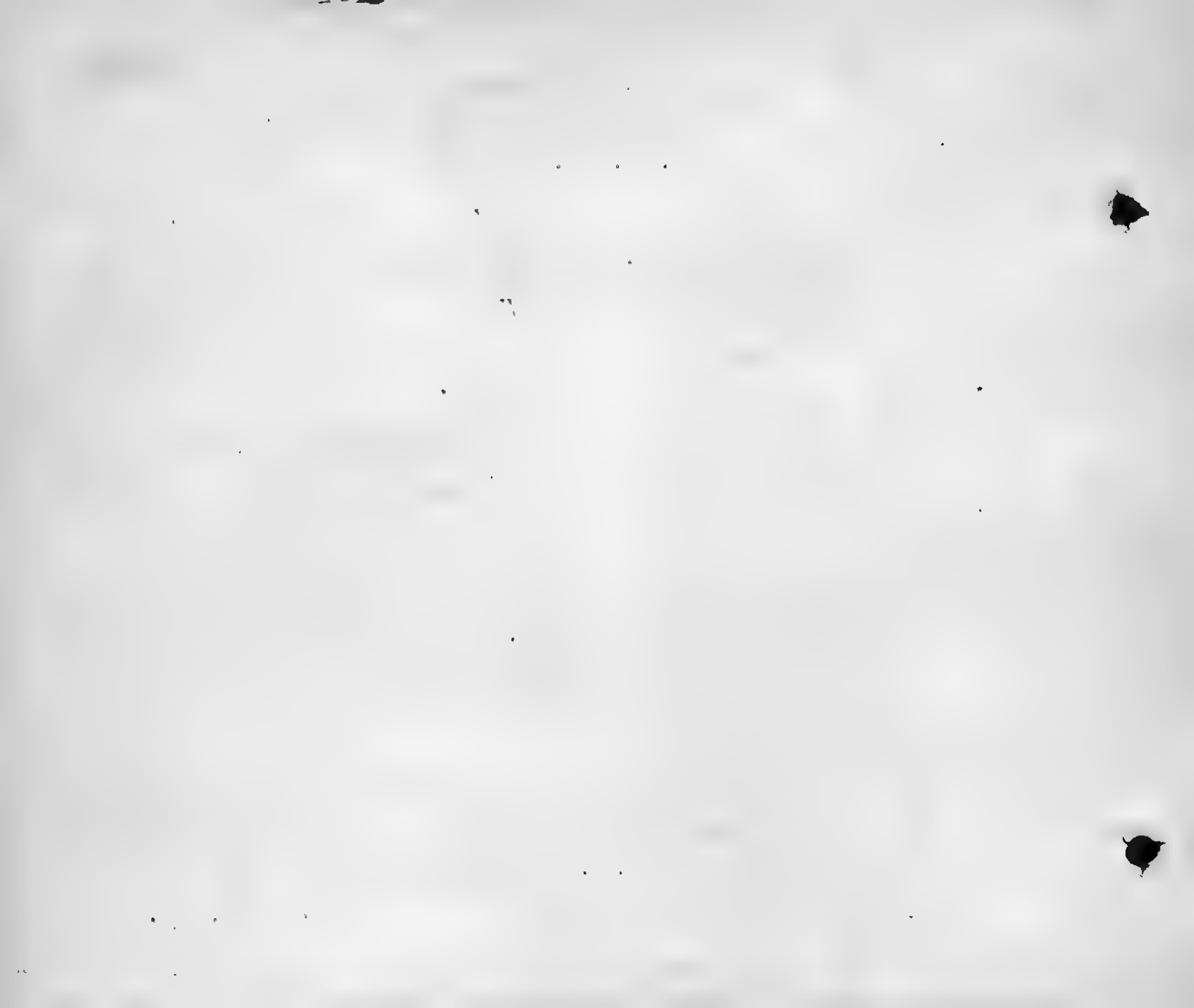
01756

CERTIFICATE OF DEATH

01739

Item 2 Film G307 2/19/62 ink

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN b 4ly. 7m. 10d.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS unknown--		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Helen M. Robey		4. DATE OF DEATH 2 13 19 62		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/1887		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY REGISTERED NURSE		11. BIRTHPLACE County & State, or foreign country Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Porter Robey		14. MOTHER'S MAIDEN NAME MARY A. Linthicum		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Schizophrenic Reaction, Hebephrenic Type.		19. INTERVAL BETWEEN ONSET AND DEATH 3 days		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>		20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State) Baltimore, Md.		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (th's hospital) attended the deceased from 7/3/1962 to 2/13/1962 , that (X) (we) last saw the deceased alive on 2/13/1962 , and that death occurred at 3:10 PM from the causes and on the date stated above.		22a. SIGNATURE Naci N. Buyukunsal, M.D.		22b. DATE SIGNED 2/13/62		22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland		22e. REC'D BY REGISTRAR FEB 15 '62		22f. REGISTRAR'S SIGNATURE Arthur S. Hanna		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/15/62		23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE H W Meard + son		24b. ADDRESS 805 N. Calvert St.		24c. DATE FEB 15 '62		24d. REGISTRAR'S SIGNATURE Arthur S. Hanna		24e. DATE FEB 15 '62		24f. REGISTRAR'S SIGNATURE Arthur S. Hanna		24g. DATE FEB 15 '62		24h. REGISTRAR'S SIGNATURE Arthur S. Hanna		24i. DATE FEB 15 '62		24j. REGISTRAR'S SIGNATURE Arthur S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01757

01740

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith Viola Salley</u>		4. DATE OF DEATH Month Day Year <u>February 12, 1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 5, 1900</u> 9. AGE (In years last birthday) <u>61</u> yrs. If UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Harry Hare</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>215-32-8339</u> 17. INFORMANT <u>Mr. James Salley, Route #1, Taneytown, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), (b), or (c). <u>21</u> DUE TO <u>Cerebral Hemorrhage</u> <u>Stroke 2 1/2 Months ago</u> <u>Adiposclerosis</u> <u>Diabetes Mellitus</u> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY Home farm factory, street, office bldg. etc) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1951</u> to <u>Feb. 12, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 27, 1962</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Rogers T. Gobel</u> 22b. DATE SIGNED <u>2-13-62</u> 22c. PHYSICIAN'S NAME (Type) <u>R.T. Gobel, M.D.</u> 22d. ADDRESS <u>245 Baltimore Street, Hanover, Pa.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 15, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Taneytown, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Skiles</u> 25a. REC'D BY REGISTRAR <u>FEB 15 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			

FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 10 Film G307

01758 **01741**

1. PLACE OF DEATH
a. COUNTY **CARROLL**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **SYKESVILLE**
c. LENGTH OF STAY IN b. **12 days**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **SPRINGFIELD STATE HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE **MARYLAND**
b. COUNTY **Frederick**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **MYERSVILLE**
d. STREET ADDRESS **1 X**

3. NAME OF DECEASED (Type or print)
First **MIRIAM** Middle **PAULINE** Last **SHEPLEY**

4. DATE OF DEATH
Month **2** Day **4** Year **1962**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **December 31, 1904** 9. AGE (In years last birthday) **57**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife** 10b. KIND OF BUSINESS OR INDUSTRY **own home** 11. BIRTHPLACE (State or foreign country) **Frederick, Co. Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Walter Lizer** 14. MOTHER'S MAIDEN NAME **Estie Shepley**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **220-40-0392** 17. INFORMANT **Clarence F. Shepley, Myersville, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Bronchopneumonia**
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Gunshot wounds of neck**
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. **Shot self in neck**
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **8:00 a.m. 1-12 1962** 20d. INJURY OCCURED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 20f. (City or town) (County) (State) **Myersville, Frederick Co., Md.**

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Peter W. Rieckert** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **2-5-62**

EXAMINER'S NAME (Type) **Peter W. Rieckert, M.D.** Address (Street, city, town, or county) **St. Paul's Lutheran, Fred Co. Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **Feb. 7, 1962** 22c. NAME OF CEMETERY OR CREMATORY **St. Paul's Lutheran** 22d. LOCATION (City, town, or country) (State) **Myersville, Fred Co. Md.**

23. FUNERAL DIRECTOR **Paul F. Bittle** ADDRESS **Myersville, Md.** 24a. REC'D BY REGISTRAR **FEB 8 '62** 24b. REGISTRAR'S SIGNATURE **L. N. N.**



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

01759

CERTIFICATE OF DEATH

Reg. No. 01742

1 PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. STREET ADDRESS <u>179 Willis St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>179 Willis St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS DONALD SHRIVER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired mechanical engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Weynesboro Pa</u>	12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. BIRTHPLACE (State or foreign country)		13. FATHER'S NAME <u>Edward Haines Shriver</u>	
14. MOTHER'S MARRIED NAME <u>Margaret Ellen Lynch</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give unit or dates of service) <u>Yes World War II</u>	
16. SOCIAL SECURITY NO. <u>182-09-9386</u>		INFORMANT <u>Mrs. F. D. Shriver</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>	
20d. INJURY OCCURRED <u> </u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I attended the deceased from <u>June 1958</u> to <u>Feb 7</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>62</u> , and that death occurred at <u>4:15</u> P.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster, Md</u>	
DATE SIGNED <u>2-7-62</u>		PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) <u>Westminster, Md</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Myers, Jr., Westminster, Md</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>FEB 13 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon part 3 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01760
CERTIFICATE OF DEATH

01743

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 'b Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pullen Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Libertytown d. STREET ADDRESS 11 X 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joanna Morris Simpson		4. DATE OF DEATH Month February Day 28 Year 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1884	
9. AGE In years (If UNDER 1 YEAR, If UNDER 24 HRS., last birthday) 77 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE County & State, or foreign country Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Edgar Morris		14. MOTHER'S MAIDEN NAME Fannie Browning	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. F. Loraine Simpson		Address Libertytown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 422 DUE TO congestive cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 2 yrs DUE TO Pyelonephritis chr. Myocarditis 3 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 4		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1962 to Feb. 28, 1962 , That (I) (we) last saw the deceased alive on Feb. 25, 1962 and that death occurred at 9:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Marcell N. Martin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MORRELL-N-MARTIN		22d. ADDRESS Sykesville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1962	
23c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		23d. LOCATION (City, town or county) (State) Libertytown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dealey and Son		25a. REC'D BY REGISTRAR 5 '62	
25b. REGISTRAR'S SIGNATURE Robert E. Dealey and Son		25c. DATE 5 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01761

01744

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY in 1b <u>Life</u>		d. STREET ADDRESS <u>Rt 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CALVIN E. SLONAKER</u>		4. DATE OF DEATH <u>Feb 9 1962</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-13-67</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith (Retired)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Slonaker</u>		14. MOTHER'S MAIDEN NAME <u>Susan Eckard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Cora Lawyer, Rt 1, Westminster, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>Feb 2 1962</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2 - Feb 9 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 9 1962</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James T. Marsh</u>			
22b. DATE SIGNED <u>2-9-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>			
22d. ADDRESS <u>Westminster</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>2/12/62</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Silver Run, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Skiles</u>			
ADDRESS <u>Taneytown, Maryland</u>			
25a. REC'D BY REGISTRAR <u>FEB 13 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>C. Stuart L. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01762

01745

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN b. <u>3yrs.7mos.23days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 13</u> d. STREET ADDRESS <u>1740 Harford Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 30, 1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Snyder</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>212-05-3467</u> 17. INFORMANT <u>Springfield Hospital Records</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive heart failure</u> (a), stating the underlying cause last. DUE TO (c) <u>Chronic brain syndrome associated with dist. of metabolism, with senile brain disease with psychotic reaction.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic brain syndrome associated with dist. of metabolism, with senile brain disease with psychotic reaction.</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Springfield</u> (County) <u>Carroll</u> (State) <u>Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from June 19, 1958 to February 12, 1962 that (I) (we) last saw the deceased alive on February 11, 1962, and that death occurred at 2:10 AM from the causes and on the date stated above. 22a. SIGNATURE <u>Agustin del Campo</u> 22b. DATE <u>2/12/62</u> 22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u> 22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/15/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE Cem</u> 23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>L. F. Ruck</u> ADDRESS <u>5305 HARFORD RD.</u> 25a. REC'D BY REGISTRAR <u>Charles E. Evans</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u> DATE <u>FEB 13 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNER. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01763

01746

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marcheston</u>		c. LENGTH OF STAY IN 1b <u>1940</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>Hampstead ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linnie Esther Snyder</u>		4. DATE OF DEATH Month Day Year <u>February 4 1962</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24 1893</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>219-36-1364</u>	
17. INFORMANT <u>Mrs. Wilson Rill</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Parkinson Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>— — —</u>	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 1 1950</u> to <u>Feb 4 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 2 1962</u> and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M. D.		ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Feb 7 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>Hampstead, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-7-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		23d. LOCATION (City, town, or county), (State) <u>Cumuld Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley</u>		ADDRESS <u>Hampstead Md</u>	
25a. REC'D BY REGISTRAR <u>Feb 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Wesley</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01764

CERTIFICATE OF DEATH

Reg. Dist. No. 01747

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 CHURCH ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHARINE SLINGLUFF STAUFFER</u>		4. DATE OF DEATH Month Day Year <u>FEB 22 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 22 - 1867</u>
9. AGE (In years last birthday) yrs. <u>94</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11c. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS SLINGLUFF</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CROMWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROBERT SLINGLUFF</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic secretory carcinoma disease</u> DUE TO + 22.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>Feb 22, 1962</u> , that I last saw the deceased alive on <u>Feb 15, 1962</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Tharal</u>		ADDRESS (Street, city or town, state) <u>Windsor, Md.</u>	
DATE SIGNED <u>2/23/62</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/25/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartley & Sons</u>		ADDRESS <u>New Windsor, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 27 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Clarence L. Hanna</u>	

<div style="display: flex; justify-content: space-between;"> Form 1 - 21 Film 5100 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="display: flex; justify-content: space-between;"> Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01748 </div>										
<div style="display: flex; justify-content: space-between;"> Item 4 Film 5100 1/4/62 </div>										
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINISTER c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINISTER d. STREET ADDRESS Mayberry Road					
3. NAME OF DECEASED (Type or print) First Middle Last DAVID TINKOSIC					4. DATE OF DEATH Month Day Year Feb. 25 (Presumed) 19 62					
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/> Divorced <input type="checkbox"/>					8. DATE OF BIRTH unknown 9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours M.n.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) unknown/ Yugoslavia 12. CITIZEN OF WHAT COUNTRY? unknown					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					
17. INFORMANT					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gunshot wound of chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 50%;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest - during a period of despondency										
20c. TIME OF INJURY Month, Day, Year ? Hour a.m. p.m. 2 25 1962			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Westminster Carroll Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE PETER W. RIECKERT, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-26-62					
EXAMINER'S NAME (Type)					Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF 2-27-62			22c. NAME OF CEMETERY OR CREMATORY Noted, Med. School			22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR					24a. REC'D BY REGISTRAR					
24b. REGISTRAR'S SIGNATURE					DATE MAR 2 '62					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death

VR A15 (11)
15M 9/53

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01766

01749

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Houdersville Ave</u>		d. STREET ADDRESS <u>12 Houdersville Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Thomas Cronnen Tipton</u>		4. DATE OF DEATH <u>February 7 1962</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11 - 1890</u>
9 AGE (In years last birthday) <u>71</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. B. Tipton</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bentz</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-34-4753</u>	
17 INFORMANT <u>Mrs. Addie Tipton</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 44-XX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m. <u>10</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>February 4, 1962</u> to <u>Feb 7, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 6, 1962</u> and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.		22b. DATE SIGNED <u>Feb 7 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-10-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24a. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Elmer</u>		24b. ADDRESS <u>Hampstead Md</u>	
25a REC'D BY REGISTRAR <u>Feb 13 '62</u>		25b REGISTRAR'S SIGNATURE <u>L. S. Tipton</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01767

01750

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sylkesville</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sylkesville</u> d. STREET ADDRESS _____															
3. NAME OF DECEASED (Type or print) <u>JOHN E. TROTT</u> First Middle Last				4. DATE OF DEATH <u>Feb 22 1962</u> Month Day Year															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1871</u>		9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) <u>Carpenter Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>				11. BIRTHPLACE (County & State, or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Daniel Trott</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mrs Clyde Wilson</u> Address <u>Sylkesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> (b) <u>Cor. heart failure</u> (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>4-7-1960</u> to <u>2-22-1962</u> , that (I) (we) last saw the deceased alive on <u>2-1-1962</u> , and that death occurred <u>2-22-1962</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Sari Okutman</u> M.D.								22b. DATE SIGNED _____											
22c. PHYSICIAN'S NAME (Type) <u>Sari Okutman</u>								22d. ADDRESS <u>Sylkesville, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>2/24/62</u>				23c. NAME OF CEMETERY OR CREMATORIUM <u>New Oakland</u>				23d. LOCATION (City, town or county) <u>Sylkesville, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sylkesville, Md.</u>																			
25a. REC'D BY REGISTRAR <u>Arthur H. Haight</u>								25b. REGISTRAR'S SIGNATURE <u>Arthur H. Haight</u>											
DATE <u>FEB 27 '62</u>								DATE _____											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01768
01751
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Carroll**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Springfield, Sykesville 7 mos. 9dys**
c. LENGTH OF STAY IN 1b **MARYLAND**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Springfield State Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland**
b. COUNTY **Allegany**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Eckhart Mines**
d. STREET ADDRESS **Box 135**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Sarah** Middle **Harris** Last **Twigg**

4. DATE OF DEATH
Month **February** Day **22** Year **19 62**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH **June 19, 1884** 9. AGE (In years last birthday) **77** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **-** 11. BIRTHPLACE (County & State, or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **William Harris** 14. MOTHER'S MAIDEN NAME **Catherine Cross**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes give year or dates of service) 16. SOCIAL SECURITY NO. **-** 17. INFORMANT **Springfield Hospital Records** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a.) **Cardiac insufficiency**
7-22-62 DUE TO (b) **Old age inanition.**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c.)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) **C.B.S. with senile brain disease with psychotic reaction.**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While ☐ Not While ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

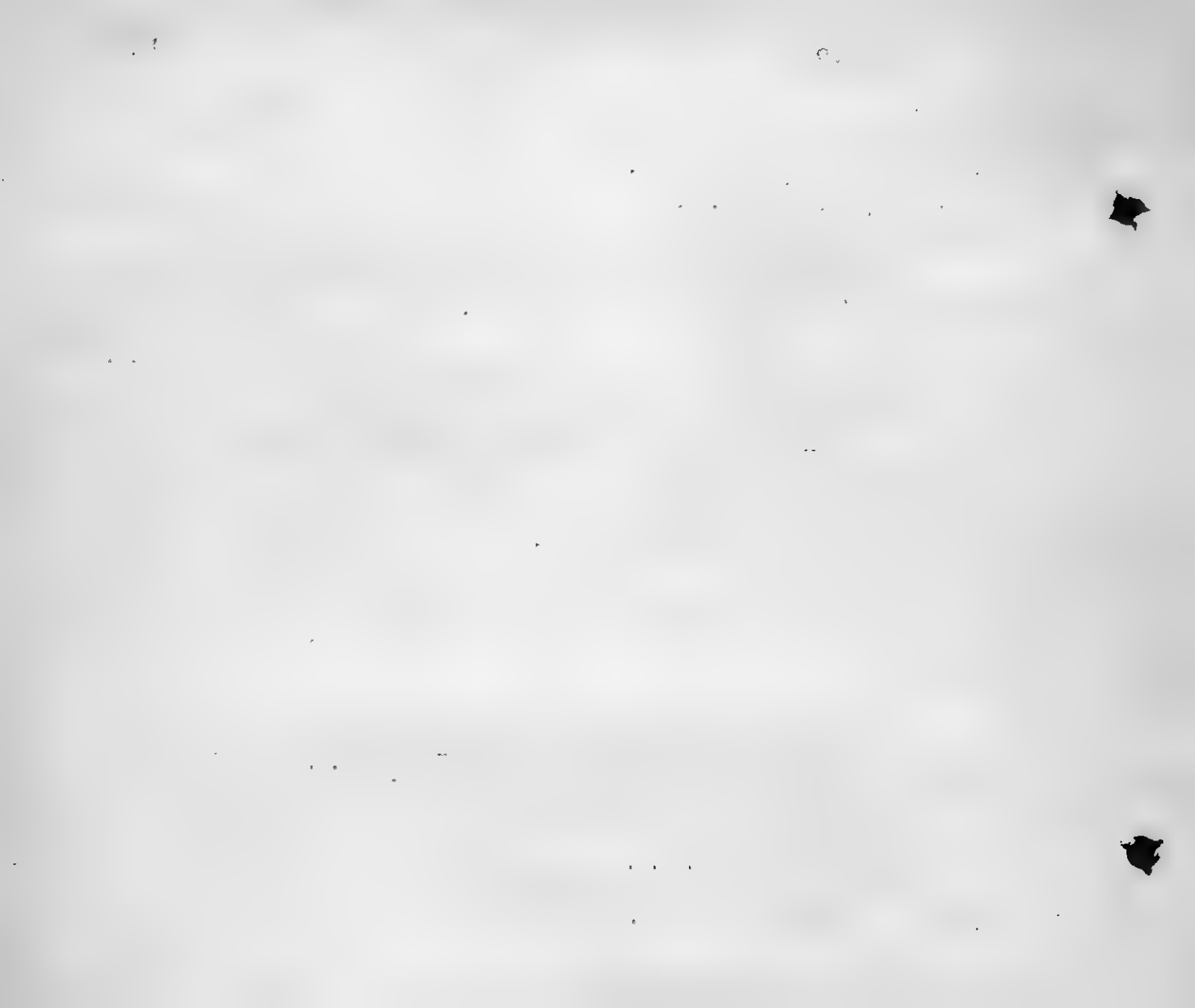
21. I certify that (I) (this hospital) attended the deceased from **7-13-1962** to **2-22-1962** that (I) (we) last saw the deceased alive on **2-22-1962**, and that death occurred at **10:15 a.m.** from the causes and on the date stated above.

22a. SIGNATURE **Naci B. Buyukunsal** M.D. 22b. DATE SIGNED **2-22-62**

22c. PHYSICIAN'S NAME (Type, **Naci Buyukunsal, M.D.** 22d. ADDRESS **Springfield State Hospital, Sykesville, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **2-25-62** 23c. NAME OF CEMETERY OR CREMATORY **F'bg. Memorial Park** 23d. LOCATION (City, town or county) (State) **Frostburg, Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **Joseph R. Sussel** ADDRESS **Frostburg, Md.** 25a. REC'D BY REGISTRAR **DATE FEB 27 '62** 25b. REGISTRAR'S SIGNATURE **C. Stuart S. Thomas**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3
01769
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01752

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3411 7</u>	
3. NAME OF DECEASED (Type or print) <u>EFFIE BROWN Walsh</u> First Middle Last		4. DATE OF DEATH <u>February 12, 1962</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>JANE WRIGHT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>O. HENRY WALSH</u> Address <u>5548 Selman Ave</u>		<u>TRIBUTUS MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Glomerular Nephritis</u> DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> g. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1959</u> to <u>February 12, 1962</u> that (I) (we) last saw the deceased alive on <u>February 12, 1962</u> and that death occurred at <u>11:35 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>2-12-62</u>	
22. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>HAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 16, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u>		23d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road, Balt., 12 Md.</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

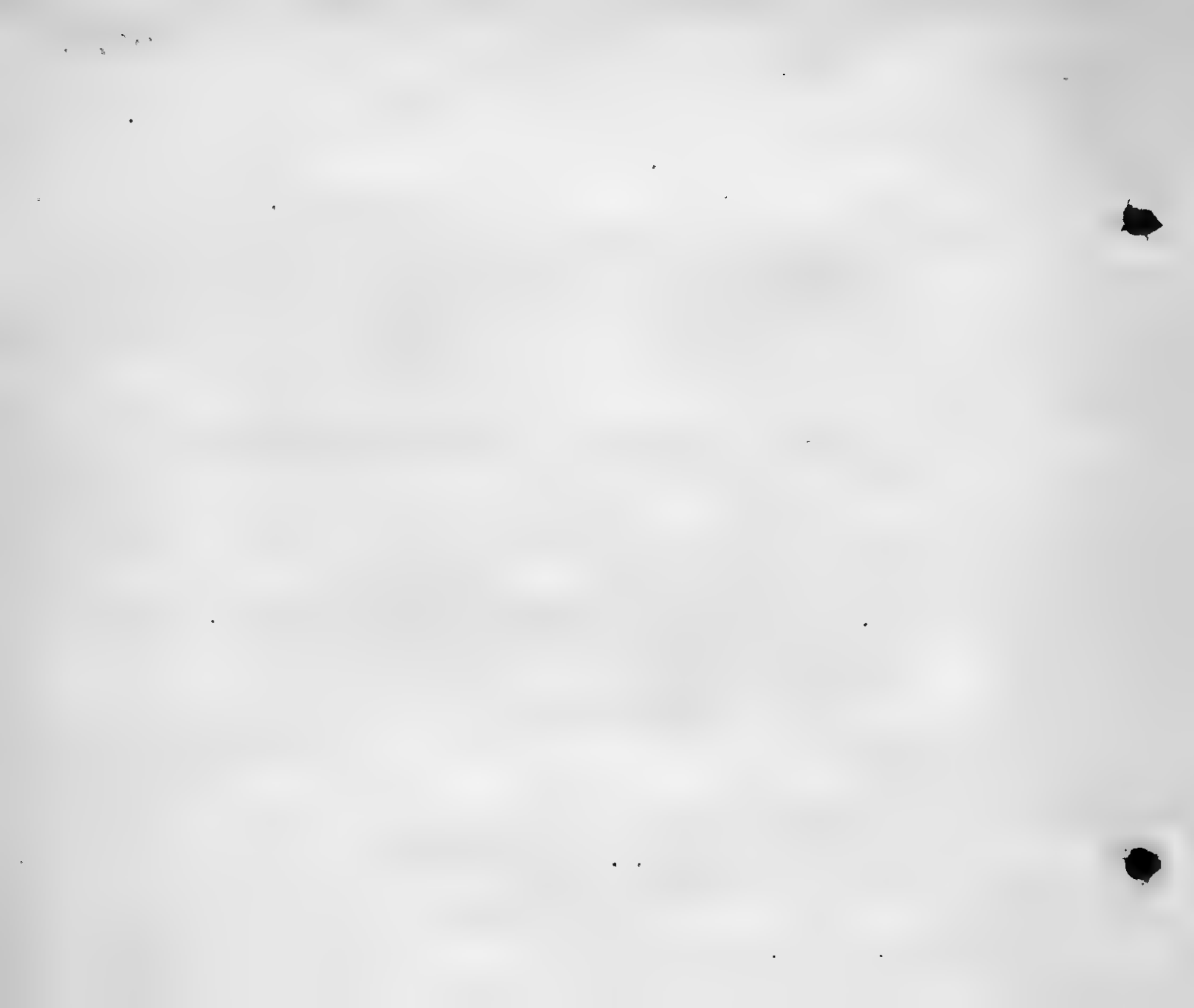
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01770

01753

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> <u>1yr. 11 days</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18</u> d. STREET ADDRESS <u>2701 Matthews St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Jefferson Walters</u>		4. DATE OF DEATH Month Day Year <u>February 12, 1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1884</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE County & State, or foreign country <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ambrose Walters</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Dietrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>216-07-9876</u>		17. INFORMANT <u>Springfield Hospital Records.</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Sepsicemia</u> <u>715X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary abscesses</u> DUE TO (c) <u>Bed sores</u>		INTERVAL BETWEEN ONSET AND DEATH Days _____ Days _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 31, 1961</u> <u>February 12, 1962</u> , that (I) (we) last saw the deceased alive on <u>February 12, 1962</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Agustin del Campo, M.D.</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>2/12/62</u> 22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 14 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>C. L. & P. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01771

01754

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN TB 2mos. 19dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 d. STREET ADDRESS 7708 Old Battle Grove Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn Pyfle Williams			4. DATE OF DEATH Month Day Year February 26 19 62		
5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 15, 1893		
9. AGE (In years last birthday) 68 yrs.			10. IF UNDER 1 YEAR Months Days		
11. IF UNDER 24 HRS. Hours Min.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher			10b. KIND OF BUSINESS OR INDUSTRY -		
11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Pete Pyfle			14. MOTHER'S MAIDEN NAME -		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. -		
17. INFORMANT Springfield Hospital Records.			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Infected bed sores DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Days weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		
C.B.S. associated with cerebral arteriosclerosis, without psychosis.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-7-1961 , to 2-26-1962 , that (I) (we) last saw the deceased alive on 2-26-1962 , and that death occurred at 7:20 p.m. on the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 2-26-62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 3, 1962		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town or county) (State) Fairmont, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DHDA 7922 Wise Ave. 22, Md.				25a. REC'D BY REGISTRAR DATE MAR 1 '62		25b. REGISTRAR'S SIGNATURE C. King L. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01772

01755

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>59 days.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u> d. STREET ADDRESS <u>3020 Texas Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> <u>Wise</u> First Middle Last		4. DATE OF DEATH <u>2</u> <u>10</u> <u>19 62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 23, 1883</u> yrs. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.- Retired</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Henry A. Wise</u>		14. MOTHER'S MAIDEN NAME <u>Minerva E. Pifer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4200 } DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, } DUE TO <u>Generalized arteriosclerosis.</u> cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fracture left hip</u> <u>C.B.S. assoc. with senile brain disease, without psychotic reaction.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fell to the floor while trying to sit down on a foot stool</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY <u>3.05</u> <u>p.m.</u> Hour e.m. Month, Day, Year <u>12-27</u> , <u>1961</u>	20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Sykesville</u> <u>Carroll</u> <u>Md.</u> (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-13-</u> <u>1961</u> <u>2-10-</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>2-10-</u> <u>1962</u> , and that death occurred at <u>9P.</u> <u>M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Agustin del Campo</u> <u>M.D.</u> 22b. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	22b. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-14-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	23d. LOCATION (City, town or county) <u>Stephens City, Va.</u> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Wright</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1962</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Wm. B. Hume</u>

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RESUME